

**FOX ARMY HEALTH CENTER
4100 GOSS RD.
REDSTONE ARSENAL, AL
Phone #(256) 876-5856
Fax# (256) 842-9917**

Date:

I, _____, hereby give my permission for the personnel of Fox Army Health Center Mammography Department to obtain and/or release medical information concerning my breast health to include but not limited to Mammography films, records, reports and biopsy pathology, on any date on or after - as needed to complete my files for their facility records.

Patient Name: _____

Patient's Signature: _____

Date: _____

Address: _____

Last 4 SSN: _____

DOB: _____

Witness: _____

Title: _____

Date: _____